north dakota
department of
human services

SFN 405 (Rev. 03-08)

Instructions For Application For Assistance

This application may be used to apply for Temporary Assistance for Needy Families (TANF), Child Care Assistance, Food Assistance, Health Care Coverage and Basic Care. See the Guidebook for more information.

What Do I Need To Do To Get Assistance?

Follow these steps to apply for assistance.

Step 1. Fill out this application.

If you are applying for:

- Child Care Assistance - You need to complete Sections 1, 2 and 6.
- Food Assistance - You need to complete Sections 1, 2, 3, 4 and 6.
- Health Care Coverage - You need to complete Sections 1, 2, 3, 5 and 6. (Aid to the Blind, Healthy Steps, Medicaid, Medicare Savings Program)
- Basic Care – You need to complete Sections 1, 2, 3, 5 and 6.
- TANF - You need to complete all Sections.

Answer as many questions as you can. If you need help applying for assistance, you may have a friend, relative or someone else help you apply. Your local county social service office can also help you apply for assistance. If you need additional space, attach a separate sheet of paper.

Step 2. Return the application to your local county social service office.

If you cannot fill out the whole application today, turn in Section 1. **If you do not fill out all of Section 1, you have the right to file an incomplete application as long as it contains the applicant's name, address and signature of either the applicant or the authorized representative.** If you are eligible, your assistance will start from the date we receive Section 1 or an incomplete application.

Fill out and turn in the rest of the application as soon as you can. You can mail or drop off your application.

Step 3. Talk with us.

When we get your application for Food Assistance or TANF, we will set up an interview with you. If you miss your appointment and still wish to apply, contact your local county social service office to schedule another appointment. Health Care Coverage and Child Care Assistance do not require an interview.

Appointment Date: _____ **Appointment Time:** _____

If you miss your appointment and still wish to apply, please contact the county social service office to schedule a second appointment.

To speed up the processing of your application, turn in verifications of the following items with your application. You may also bring verifications with you to your interview. Your worker may be able to help you obtain these things if needed.

- ❑ **Verification of Alien or Citizenship Status such as** (original documents required if applying for Health Care Coverage):
  - Resident Alien Card (Form I-551)
  - Employment Authorization Card (Form I-688A)
  - Temporary Resident Card (Form I-688)
  - Arrival-Departure Record (Form I-94)

  You will be asked to provide information about the citizenship or immigration status for all persons for whom you want to receive assistance. If any of these persons do not want to give information about their citizenship or immigration status, they will not be eligible for benefits. Other household members may still get benefits if they are otherwise eligible. We will not share alien or citizenship information about non-applicants with the United States Citizenship and Immigration Service (USCIS).

- ❑ **Verification of the value of current assets such as**:
  - Annuities
  - Business Accounts
  - Certificates of Deposit
  - Checking/Savings/Credit Union Accounts
  - IRA/401K/KEOGH plans
  - Life Insurance
  - Real Property (Land, Rental Property, etc.)
  - Saving Bonds
  - Stocks/Bonds/Mutual Funds
  - Trusts

  If only applying for Child Care Assistance or Health Care Coverage for children and family coverage, you do not need to report or bring records of your assets.

- ❑ **Verification of expenses such as:**
  - Child/Dependent Care
  - Court Ordered Payments (Child Support, Health Insurance Premiums, Other Support)
  - Medical or Health Insurance Premiums (If applying for Food Assistance only, you do not need to provide information for household members under age 60 unless they are disabled.)
  - Utility/Shelter Expenses (If applying for Food Assistance)
    - Heating and Cooling Costs
    - Home Owner's Insurance
    - House Payment
    - Other Utility Bills
    - Property Taxes
    - Rent (Receipt, Lease Agreement, Housing Assistance Contract)
    - Telephone Bill

- ❑ **Verification of income such as:**
  - Bonuses
  - Child Support
  - Commissions
  - Lease Income
  - Money from Friends, Relatives or Others
  - Pay (Pay Stubs or Employer Statement)
  - Pension/Retirement Benefits
  - Rental Income
  - Self-Employment Income
  - Social Security Benefits
  - Spousal Support
  - SSI
  - Unemployment Benefits
  - Veterans'/Military Benefits
  - Workers Compensation

- ❑ **Verification of other information such as:**
  - Identity (Birth Certificate, Driver's License, Work or School ID - original documents required if applying for Health Care Coverage)
  - Age (Birth Certificate, Driver's License)
  - Residence (Rent Receipts, Utility Bills, Lease)
  - Social Security Numbers
  - Verification of Pregnancy (Doctor's statement of due date)

To learn when you may get assistance, go to the General Information section of the Guidebook. If you have questions, contact your local county social service office.

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Agency Use Only	
Case Number:	Date Requested:
Date Received:	Interview Date:
Individual Interviewed:	

Application For Assistance – Section 1

Check the assistance you are applying for. Sign and date below.

If you would like more information on these programs, see the Guidebook. If you did not receive the Guidebook, contact your local county social service office.

☐ **Temporary Assistance for Needy Families (TANF) –** Provides a monthly payment on behalf of children who are considered dependent and deprived of parental support.

☐ **Child Care Assistance –** Helps adults continue working to support their families and helps teen parents remain in school by assisting with the costs of child care.

☐ **Food Assistance (also known as Food Stamps)** - Helps people buy food for good health.

You may get Food Assistance within 7 days of your application date if any of the following are true:

- Your household's monthly income before taxes is $150 or less and your household's assets, such as cash and checking/savings accounts are $100 or less; or
- You are a migrant or seasonal farm worker and your household's assets, such as cash and checking/savings accounts are $100 or less; or
- Your household's monthly rent/mortgage and utilities are more than your household's income before taxes, cash and checking/savings accounts.

☐ **Health Care Coverage –** Assistance available for families with children, pregnant women, elderly, or disabled people to help pay medical bills and health insurance premiums.

Check the Health Care Coverage(s) you are applying for:

- ☐ **Aid to the Blind –** Assists with treatment for people who are not eligible for Medicaid and are in danger of losing their vision or require restorative eye services.
- ☐ **Healthy Steps (State Children's Health Insurance Program - SCHIP)** – Provides premium-free health insurance coverage to uninsured children.
- ☐ **Medicaid –** Pays for health services for families with children, pregnant women and people who are elderly or disabled.
- ☐ **Medicare Savings Program –** Assists with Medicare Part B premium, coinsurance and deductibles.

☐ **Basic Care Assistance –** Helps pay for care in licensed basic care facilities.

Sign And Date The Application Here

Signature of Applicant: _____ Date: _____

Other Signature (Spouse, Guardian or Other Adult): _____ Date: _____

Tell Us About You

First Name	Middle Initial	Last Name
Address Where You Live		
City	State	Zip Code
Mailing Address (If different)		
Home Telephone Number:	Work or Message Number:	Cell Phone Number:
Directions to Home (if rural):		

Tell Us About The People In Your Home

Check the boxes below for all the people who live in your home, including members temporarily out of your home (working away from home, attending school or boarding school, in the military):

- ❑ Yourself
- ❑ Your husband or wife
- ❑ Your children
- ❑ Other adults or children living in your home

For each person checked, fill in the boxes below. These people make up your household.

If you need additional space, continue on a separate sheet of paper.

Refer to the General Information section of the Application for Assistance Guidebook to determine what information is optional for you to provide.

Household Members (Enter Legal Name) First / Middle Initial / Last	Relation To You	Social Security Number	Date of Birth	Age	Sex	Last Grade Completed	U.S. Citizen (Yes or No)	Hispanic or Latino (Yes or No)	Race (Use Codes Below)	Marital Status (Use Codes Below)
	SELF									

Race Codes: AI-American Indian/ Alaska Native; AP-Asian; BL–Black/ African American; HP-Native Hawaiian/ Pacific Island; WH – White

Marital Status Codes: DI – Divorced; MA–Married; NM-Never Married; SE-Separated; WI – Widowed

List other names that have been used by household members (maiden name, prior married name or nicknames): _____

_____

List household members temporarily out of the home: _____

Why are they out of the home? _____ Date expected to return: _____

List household members who are disabled: _____

List household members who are a veteran, or a dependant or spouse of a veteran: _____

Have household members received assistance in another state (cash, food, medical assistance)? ❑ Yes ❑ No

If yes, when? _____ Which city, county and state? _____

List household members who are boarders (paying someone to provide meals): _____

Tell Us About Students In Your Home

List each household member age 14 or older who is a student or planning to attend school.

Student Name	Name of School	PT-Part Time FT-Full Time

Can You Choose Someone To Help You Get Food Assistance?

If you are applying for Food Assistance you can have someone help you, if you wish. This person can fill out your application, answer questions for you, give information at your interview, and buy your food with an EBT card. We will be able to share information with this person.

If you choose to have someone help you, fill in the boxes below with their information:

Name:		Telephone Number:	
Address:	City:	State:	Zip Code:

Help Us Decide If You Can Receive Food Assistance Within Seven Days

If you are applying for Food Assistance, completing this section may help you receive benefits within seven days:

Are you a migrant or seasonal farm worker? ❑ Yes ❑ No

About how much total earned income will your household receive this month before taxes (gross)? _____

About how much total unearned income or other money will your household receive this month? _____

About how much money does your household have (cash, checking, savings, etc.)? _____

How much is your household's monthly rent, lot rent and house payment? _____

Check all the utilities your household is responsible for:

❑ Heating ❑ Cooling ❑ Electricity ❑ Telephone ❑ Water ❑ Sewer ❑ Garbage

Do household members receive heating assistance (LIHEAP)? ❑ Yes ❑ No

Do household members plan to apply for heating assistance (LIHEAP)? ❑ Yes ❑ No

Do you have a North Dakota Electronic Benefit Transfer (EBT) card  for Food Assistance? ❑ Yes ❑ No

Have you received EBT training? ❑ Yes ❑ No

Have household members received tribal commodities last month or this month? ❑ Yes ❑ No

Do household members purchase and prepare meals separately? ❑ Yes ❑ No

If yes, who? _____

Agency Use Only – Expedited Formula

If:	If not:	
Income below $150/month Wages, Child Support, SSI, Disability, Retirement, Veterans Benefits, Unemployment, Workers Compensation AND **Liquid Assets that do not exceed $100/month** Cash on hand, checking, savings, CD's, Bonds, Stocks If yes to both = Household Expedited	**Monthly** Gross Income _____ Liquid Assets +_____ =_____ Would be less than: Rent/Mortgage _____ Appropriate Utility Standard +_____ =_____	HLSU – Any of the following: • Heating • Cooling • LIHEAP LUSA – Two of the following: • Water • Sewer • Garbage • Electric • Telephone MU – One of the following: • Water • Sewer • Garbage • Electric TL – Telephone Only
Was the screening for expedited service completed? ❑ Yes ❑ No Is the household eligible for expedited service? ❑ Yes ❑ No Was the identity of applicant verified? ❑ Yes ❑ No		Worker Initials:

Agency Use Only
Case Number:
Date Received:

Application For Assistance – Section 2

Complete Section 2 if you are applying for any one of the following:

- **Basic Care**
- **Child Care Assistance**
- **Food Assistance**
- **Health Care Coverage**
- **TANF**

Your Name: _____

Tell Us About The Income/Money Your Household Receives

Self-Employment

Are any household members self-employed? ❑ Yes ❑ No

If yes, list the household member, name and type of business and date business started: _____

_____

Employment

Are any household members employed? ❑ Yes ❑ No

If yes, list information about pay from employment such as wages, commissions, bonuses, and incentives for all household members including children:

Household Member	Employer	Hours Worked Per Week	Hourly Pay	This Month's Pay Before Taxes (Gross)	Next Month's Pay Before Taxes (Gross)	Amount of Tips	Date of Next Check	How Often Paid (Use Codes Below)	Day or Dates Paid (Use Codes Below)

How Often Paid Codes:
M – Monthly 2X – Twice a Month W – Weekly EX – Every Two Weeks Other, specify: _____

Day Paid Codes:
M – Monday T – Tuesday W – Wednesday TH – Thursday F – Friday S – Saturday SU - Sunday

Has any household member received commissions, bonuses or incentives other than those included above within the last year? ❑ Yes ❑ No

If yes, list the household member, date received and amount. _____

Unearned Income or Other Money Received

The following is a list of different kinds of unearned income. Check yes for each unearned income or other money received by household members. Check no, if not received.

❑ Yes ❑ No BIA/Tribal General Assistance
❑ Yes ❑ No Bingo/Gambling Winnings
❑ Yes ❑ No Child Support or Spousal Support
❑ Yes ❑ No Contract Sale or Rental Income
❑ Yes ❑ No Income from Tribes
❑ Yes ❑ No Income from Roomer/Boarder
❑ Yes ❑ No Individual Indian Monies (IIM)
❑ Yes ❑ No Insurance/Lawsuit Settlement
❑ Yes ❑ No Interest/Dividend Income
❑ Yes ❑ No Money from Friends, Relatives or Others
❑ Yes ❑ No Oil/Mineral Rights/Royalties
❑ Yes ❑ No Pension/Retirement Benefits
❑ Yes ❑ No Railroad Retirement Benefits
❑ Yes ❑ No Social Security Benefits
❑ Yes ❑ No Supplemental Security Income (SSI)
❑ Yes ❑ No TANF
❑ Yes ❑ No Unemployment Benefits
❑ Yes ❑ No Veterans'/Military Benefits
❑ Yes ❑ No Workers' Compensation
Other, specify: _____

For all items checked yes, fill in the boxes below:

Type of Unearned Income or Other Money Received	Household Member	How Often Received	Amount This Month	Amount Next Month

Have household members applied for benefits not yet received (Social Security, SSI, Workers' Compensation, Unemployment Compensation, Veterans'/Military Benefits)? ❑ Yes ❑ No

If yes, explain: _____

Tell Us If You Have Child Care Needs

Does or will your household have child care expenses? ❑ Yes ❑ No If yes, when? _____

What is the monthly billed amount? _____ What amount do you pay? _____

Child Care Assistance can help pay child care expenses for the month prior to the application. Would you like help paying for last month's child care expenses? ❑ Yes ❑ No

Check the reason for needing child care:

❑ High School ❑ Employment ❑ Vocational Training/College ❑ Other, specify: _____

If attending college or vocational training, list household members who have a previous degree: _____

Are you already receiving Child Care Assistance? ❑ Yes ❑ No If no, have you applied? ❑ Yes ❑ No

Does anyone help you pay your child care expenses? ❑ Yes ❑ No

If yes, list who is paying and how much they pay: _____

Do you expect changes in the above expenses next month? ❑ Yes ❑ No If yes, explain: _____

Application For Assistance – Section 3

Complete Section 3 if you are applying for any one of the following:

- **Basic Care**
- **Food Assistance**
- **Health Care Coverage**
- **TANF**

Tell Us The Value Of Your Household's Assets

If you are applying for Health Care Coverage for a child or pregnant woman, answer one of these questions. Answering the question may help North Dakota get additional funding for Health Care Programs. Your answer will not affect your eligibility or the amount of your benefits.

If you **live alone**, is the value of all assets more than $3,000? (Do not count the value of one vehicle, your home, clothing, household goods, and real property used as part of your business.) ❑ Yes ❑ No

If you **live with someone**, is the value of all assets more than $6,000? (Do not count the value of one vehicle, your home, clothing, household goods, and real property used as part of your business.) ❑ Yes ❑ No

Tell Us About Your Household Assets

If you are applying for Medicaid for someone who is disabled or age 65 or older, or if you are applying for Basic Care, Food Assistance or TANF, you must complete the Vehicles and Other Assets sections.

Vehicles

List vehicles (car, truck, motor home, snowmobile, motorcycle, 3 wheeler/4 wheeler, boat or other watercraft, camper, trailer, etc.) owned, jointly owned or being purchased for all household members, even if the vehicle is not running or not in your possession. Include vehicles licensed through North Dakota, tribal motor vehicle or another state.

Make/Model	Year	Value	Amount Owed	Licensed	Owners
		$	$	☐ Yes ☐ No	
		$	$	☐ Yes ☐ No	
		$	$	☐ Yes ☐ No	
		$	$	☐ Yes ☐ No	
		$	$	☐ Yes ☐ No	
		$	$	☐ Yes ☐ No	

Other Assets

Check yes by the assets owned, jointly owned or being purchased by household members. Check no, if none.

- ❑ Yes ❑ No Annuities
- ❑ Yes ❑ No Assets Owned with Another Person
- ❑ Yes ❑ No Burial Plots
- ❑ Yes ❑ No Burial Space Items (Casket, Vault, Marker, etc.)
- ❑ Yes ❑ No Business Accounts
- ❑ Yes ❑ No Business Inventory/Equipment
- ❑ Yes ❑ No Cash on Hand
- ❑ Yes ❑ No Certificates of Deposit
- ❑ Yes ❑ No Checking/Credit Union Accounts
- ❑ Yes ❑ No Farm Equipment, Livestock, Stored Grain
- ❑ Yes ❑ No Home/Mobile Home (Not Owner Occupied)
- ❑ Yes ❑ No Home/Mobile Home (Owner Occupied)
- ❑ Yes ❑ No Income Producing Tools/Equipment
- ❑ Yes ❑ No Individual Indian Monies Accounts
- ❑ Yes ❑ No Life Estate/Life Lease
- ❑ Yes ❑ No Mineral Rights (Oil, Gas, Gravel, Coal, etc.)
- ❑ Yes ❑ No Notes or Contract for Deed
- ❑ Yes ❑ No Prepaid Funeral Plans
- ❑ Yes ❑ No Real Property (Land, Rental Property, Buildings, etc.)
- ❑ Yes ❑ No Retirement Funds (IRA/KEOGH/401K)
- ❑ Yes ❑ No Safety Deposit Box
- ❑ Yes ❑ No Savings Bonds
- ❑ Yes ❑ No Savings/Credit Union Accounts
- ❑ Yes ❑ No Stocks/Bonds/Mutual Funds
- ❑ Yes ❑ No Trusts

Other, specify: _____

For all items checked yes, fill in the boxes below:

Type of Asset	Location/Description	Total Value	Amount Owed	Owners

List household members who have made arrangements for funeral expenses or gave money, property, or insurance to someone else to pay for funeral expenses: _____

Explain: _____

Do you expect changes in assets next month? ❑ Yes ❑ No

If yes, explain: _____

Transfer of Assets

Have household members sold, given away or transferred anything of value within the past 5 years? ❑ Yes ❑ No

If yes, list the items: _____ Date: _____

Tell Us About Court Ordered Expenses

Is any household member court ordered to pay child support, health insurance, or other support payments? ❑ Yes ❑ No

If yes, who? _____ Who are the payments for? _____

Amount court ordered: _____ Amount paid: _____

Application For Assistance – Section 4

Complete Section 4 if you are applying for:

- **Food Assistance**
- **TANF**

Tell Us About Your Housing Expenses

Check yes by each expense household members have during any time of the year. Check no, if none.

❑ Yes ❑ No Air Conditioning or Central Air
❑ Yes ❑ No Condo Fees
❑ Yes ❑ No Electricity
❑ Yes ❑ No Garbage
❑ Yes ❑ No Heating (gas, propane, electric, etc.)
❑ Yes ❑ No Homeowners Insurance (not in house payment)
❑ Yes ❑ No House Payment (mortgage)
❑ Yes ❑ No Lot Rent
❑ Yes ❑ No Property Taxes (not in house payment)
❑ Yes ❑ No Rent
❑ Yes ❑ No Sewer/Septic Tank Installation or Maintenance
❑ Yes ❑ No Telephone/Cell Phone
❑ Yes ❑ No Use of a Garage
❑ Yes ❑ No Water/Well Installation or Maintenance

For all items checked yes, fill in the boxes below:

Type of Expense	Who Pays the Expense	Total Amount	Amount Household Member Pays

Do household members work off part of an expense (rent, lot rent, utilities, etc.)? ❑ Yes ❑ No

If yes, list the expense and the amount worked off: _____

Do household members receive heating assistance (LIHEAP)? ❑ Yes ❑ No

Do household members plan to apply for heating assistance (LIHEAP)? ❑ Yes ❑ No

Do you expect changes in expenses (rent, lot rent, utilities, etc.) next month? ❑ Yes ❑ No

If yes, explain: _____

Does anyone help you pay these expenses (government agency, family member, etc.)? ❑ Yes ❑ No

If yes, list the expense, who is paying the expense and the amount they pay: _____

Agency Use Only
Household is entitled to one of the following mandatory utility standards: ❑ HL SU (heating/cooling/LIHEAP) ❑ MU (water, sewer, garbage, electricity) ❑ LU SA (water, sewer, garbage, electricity, telephone) ❑ TL (telephone only)

Tell Us About Expenses For Elderly Or Disabled Household Members

Do household members, who are disabled or age 60 or older, pay health insurance or medical expenses? ❑ Yes ❑ No

If yes, who? _____

Health insurance amount: _____ Medical expense amount: _____

Does anyone help you pay these expenses? ❑ Yes ❑ No If yes, explain: _____

Do household members pay representative payee fees? ❑ Yes ❑ No

Do you expect changes in expenses next month? ❑ Yes ❑ No If yes, explain: _____

Tell Us About Your Household's Work Information

List household members who are unable to work: _____

Reason: _____

List household members who stopped their employment within the last 30 days: _____

When: _____ Employer: _____

Check the reason for leaving: ❑ Laid Off ❑ Quit ❑ Fired ❑ Leave of Absence ❑ Strike

❑ Illness ❑ Injury ❑ Other, specify: _____

List household members who reduced their work hours: _____

When: _____ Reason: _____

List household members who refused work within the last 30 days: _____

Tell Us About Illegal Activities And Disqualifications

Are household members currently or have they been:

Convicted of buying or selling food assistance benefits of $500 or more? ❑ Yes ❑ No

Found to have fraudulently represented their identity or place of residence to receive multiple food assistance benefits? ❑ Yes ❑ No

Subject to an arrest warrant issued by an authority outside North Dakota's jurisdiction? ❑ Yes ❑ No

Violating parole or probation? ❑ Yes ❑ No

Convicted of a felony for possession, use, or distribution of a controlled substance after August 22, 1996? ❑ Yes ❑ No

Disqualified from the Food Assistance program? ❑ Yes ❑ No

Application For Assistance – Section 5

Complete Section 5 if you are applying for either of the following:

- **Basic Care**
- **Health Care Coverage**
- **TANF**

Tell Us About Your Household

I/We have lived in North Dakota since (month, day, year): _____

Do you intend to remain in North Dakota? ❑ Yes ❑ No

List any children whose father's name is not listed on the birth certificate: _____

List each household member who is pregnant: _____

How many babies are due? _____ When is the due date? _____

How was pregnancy determined? ❑ Physician ❑ Public Health Agency ❑ Home Pregnancy Test

❑ Other, specify: _____

List the father of the unborn baby: _____

Do you pay for guardianship or conservator services? ❑ Yes ❑ No

Do both parents (natural or adoptive) live together in the home with a child under age 19? ❑ Yes ❑ No

If yes, list the name of the parent who had the most income from employment or self-employment in the past 24 months: _____

Tell Us About Parents Not Living In The Home

List each child under age 21 whose parents do not live in the home:

Name of Child Whose Parent Is Not Living in the Home	Name of Parent Who Is Not Living in the Home	Parent's Date of Birth	Parent's Social Security Number	Reason Parent Is Not Living in the Home Use Codes Below
	Mother:			
	Father:			
	Mother:			
	Father:			
	Mother:			
	Father:			
	Mother			
	Father:			

AB - Abandoned	DI - Divorced	MS - Military Service	WO – Working Out of Town or State
AN - Legally Annulled	JP - Jail/Prison	NM - Never Married	
AS - Attending School	LW - Looking for Work	PR - Parental Rights Terminated	
DE - Deceased	MC - Medical Care	SE - Separated	

Tell Us About Your Life Insurance

Does any household member have life insurance? ❑ Yes ❑ No If yes, fill in the boxes below:

Name of Insured Person	Name and Address of Company	Policy Number	Face Value	Owners

Tell Us About Your Medical Bills

Medicaid can help pay medical bills, including prescription costs, for up to three months prior to the month of your application. Would you like help paying any of these bills? ❑ Yes ❑ No

If yes, list each month: _____

Medicaid can allow unpaid medical bills older than three months to reduce your out-of-pocket costs. Do household members have unpaid medical bills older than three months? ❑ Yes ❑ No

If yes, explain: _____

Tell Us About Your Primary Care Provider (PCP)

Your primary care provider (PCP) is the doctor, clinic or HMO you see for medical care. List the doctor for each household member except for those age 65 or older, a refugee or disabled. If you do not have a primary doctor, list the clinic or HMO.

Household Member	Name of PCP

Tell Us About Your Health Insurance Coverage

List household members who have health insurance:

Persons Covered	Policy Holder Name and Address	Health Insurance Name and Address	Effective Date	Policy Number	Group Number	Monthly Premium	Type of Coverage Use Codes Below

List all that apply

A - Hospital	E - Vision	I - HMO Insurance	M - Medicare Supplement/Advantage
B - Doctor	F - Nursing Home	J - Court Ordered	N - Drug Insurance
C - Major Medical/Lab/X-Ray	G - Cancer	K - Medicare Part A	P - Workers Compensation or Accident
D - Dental	H - Champus/Tricare	L - Medicare Part B	V – Veterans
			W – Medicare Part D

Does anyone outside the household pay the premium? ❑ Yes ❑ No

If yes, who: _____

Do household members expect changes in health insurance coverage? ❑ Yes ❑ No

If yes, explain: _____

Does any household member's employer offer health insurance? ❑ Yes ❑ No

If yes, does the employer pay 50% or more of the premium? ❑ Yes ❑ No

If yes, list the name of the insurance? _____

Did anyone in your household have health insurance canceled or stopped within the last six months? ❑ Yes ❑ No

If yes, who: _____ Date coverage ended: _____

Reason: _____

Tell Us If You Receive Help With Your Medical Costs

Does anyone help pay your medical costs? ❑ Yes ❑ No

If yes, explain: _____

Do household members have medical problems due to an accident? ❑ Yes ❑ No

If yes, list the date and type of the accident: _____

Do household members have a pending legal action from which they may receive money or medical benefits (including inheritance)? ❑ Yes ❑ No

Tell Us Where You Got This Application

Where did you get this Health Care Coverage application (check only one)?

- ❑ 1-877-KIDS-NOW
- ❑ Capitol in Bismarck
- ❑ Caring for Children
- ❑ Community Resource Coordinator
- ❑ Daycare
- ❑ Faith-Based Organization
- ❑ Food Pantry
- ❑ Friend/Relative
- ❑ Head Start
- ❑ Insurance Agent
- ❑ Internet
- ❑ Medical Provider
- ❑ Pharmacy
- ❑ Public Health Agency
- ❑ School
- ❑ Social Service Agency
- ❑ WIC
- ❑ Other

Tell Us How You Found Out About Health Care Coverage

How did you find out about Health Care Coverage in North Dakota (check only one)?

- ❑ Business/Service Club
- ❑ Capitol in Bismarck
- ❑ Caring Program
- ❑ Daycare
- ❑ Faith-Based Organization
- ❑ Food Pantry
- ❑ Friend/Relative
- ❑ Head Start
- ❑ Insurance Agent
- ❑ Internet
- ❑ Medical Provider
- ❑ Newspaper/Magazine/Newsletter
- ❑ Pharmacy
- ❑ Public Health Agency
- ❑ Radio
- ❑ Social Service Agency
- ❑ Television
- ❑ WIC
- ❑ Other

Information About Other Services For Children and Families

Caring For Children
If children listed on this application are not eligible for Health Care Coverage through either the Medicaid or Healthy Steps program, they may be eligible for the Caring for Children program. The North Dakota Caring Foundation, a private nonprofit organization, offers this program.

If you have children who are not eligible for Health Care Coverage through either Medicaid or Healthy Steps program, we may forward information from this application to the Caring for Children program. They will determine if any of the children listed are eligible for their program. If you do not want us to send the information to the North Dakota Caring Foundation, please check below:

❑ Check this box if you **do not** want us to forward information to the Caring for Children program.

Please note that the North Dakota Department of Human Services or county social services do not determine eligibility for the Caring for Children program and any appeal of their decision regarding this program must be made to the North Dakota Caring Foundation.

Medical Coverage
Child Support Enforcement (CSE) may help children get medical coverage from parents who do not live in the home and who are or can be court ordered to provide medical coverage. If a child is eligible for Medicaid and a parent does not live in the home, we may make a referral to CSE. We will not make a referral for children who are eligible for Healthy Steps (Children's Health Insurance Program (SCHIP)). If you have a child eligible for the Healthy Steps Program and you would like assistance from CSE, please contact them at 1-800-231-4255.

If you are interested in receiving Medicaid coverage for yourself or your children and you do not want assistance from CSE because your cooperation might not be in the best interests of your child (example: domestic violence situation), you may claim "good cause". If you do, a form will be sent to you to provide additional information so we can decide if there is "good cause".

Are you interested in claiming "good cause" for not cooperating with CSE? ❑ Yes ❑ No

Claiming "good cause" or failure to cooperate with CSE does not affect your child's eligibility. If you choose not to cooperate with CSE efforts and you have not claimed "good cause" or your claim of "good cause" has been denied, you will not be eligible for Medicade coverage. <u>However, your children will</u> continue to be eligible for Medicaid or Healthy Steps coverage, provided they meet all other program requirements.

Application For Assistance – Section 6

Read and sign Section 6 if you are applying for any one of the following:

- **Basic Care**
- **Child Care Assistance**
- **Food Assistance**
- **Health Care Coverage**
- **TANF**

Read The Following Information

I have received, reviewed and understand my rights and responsibilities as explained in the Guidebook.

I declare under penalty of law, the information on this application is correct. This includes information about identity, citizenship and alien status of the household members applying for assistance.

I understand that alien status information and other information will be verified when discrepancies are found. Verification received may affect eligibility and level of benefits.

I understand the information I provide on or with this application is subject to verification by federal, state and local officials to determine if the information is correct. If any of the information is incorrect, assistance may be denied and I may be subject to criminal prosecution for knowingly providing incorrect information.

I agree to report to the county social service office any changes in income, assets, or living arrangements as required.

I understand I will not receive a deduction for any allowable expenses I do not report and verify.

I understand that if a parent wants Medicaid coverage and is not pregnant or does not have “good cause,” the parent must cooperate with Child Support Enforcement when the other parent does not live in the home. Claiming “good cause” or failure to cooperate with Child Support Enforcement will not affect the child’s Medicaid eligibility.

I understand that unless I have indicated otherwise for the Caring for Children program, in the ‘Other Services’ section above, information may be forwarded to the Caring for Children program so they can determine if any of the children listed on this application are eligible for their program.

I have been informed my household is authorized to receive TANF Information and Referral services. I have been given the Guidebook that has information about these services.

Authorization To Release Information

I/We authorize any person having custody or knowledge of the information relating to me or other household members to disclose any requested information, including confidential information other than protected health information, to any authorized agent of the North Dakota Department of Human Services. I also authorize the North Dakota Department of Human Services and the carrier providing Healthy Steps insurance to release to each other information regarding any services or benefits I received under Healthy Steps. This authorization will remain valid until canceled in writing or until coverage ends. A copy of this authorization is as valid as the original.

Sign And Date The Application Here

Signature of Applicant: _____ Date: _____

Other Signature (Spouse, Guardian or Other Adult): _____ Date: _____